EXHIBIT

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HEALTH NET OF NEW JERSEY, INC.

HMO PLAN
SMALL GROUP HEALTH MAINTENANCE ORGANIZATION
EVIDENCE OF COVERAGE

Health Net of New Jersey, Inc. certifies that the Employee named below is entitled to Covered Services and Supplies described in this Evidence of Coverage, as of the effective date shown below, subject to the eligibility and effective date requirements of the Contract.

The Contract is an agreement between Health Net of New Jersey, Inc. and the Contractholder. This Evidence of Coverage is a summary of the Contract Provisions that affect Your Coverage. All Covered Services and Supplies and Non-Covered Services and Supplies are subject to the terms of the Contract.

This Evidence of Coverage replaces any older Evidence of Coverage issued to You for the Group Health Care Plan.

Paul Lambdin
President, Health Net of the Northeast

maintenance and, the child of his or her domestic partner if the child depends on the Employee for most of his or her support and maintenance, and children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

A Dependent is not a person who is on active duty in the armed forces of any country.

A Dependent is not a person who is covered by the Contract as an Employee.

At Our discretion, We can require proof that a person meets the definition of a Dependent.

DEPENDENT'S ELIGIBILITY DATE.
The later of:
a) the Employee's Eligibility Date; or
b) the date the person first becomes a Dependent.

DEVELOPMENTAL DISABILITY or DEVELOPMENTALLY DISABLED. A severe, chronic disability that:
a) is attributable to a mental or physical impairment or a combination of mental and physical impairments;
b) is manifested before the Member attains age 19;
c) is likely to continue indefinitely;
d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency;
e) reflects the Member's need for a combination and sequence of special interdisciplinary or generic services, individualized support, and other forms of assistance that are lifelong or of extended duration and are individually planned and coordinated.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:
a) radiology, ultrasound, and nuclear medicine;
b) laboratory and pathology; and
c) EKG's, EEG's, and other electronic diagnostic tests.

DISCRETION / DETERMINATION / DETERMINE. Our sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:
a) designed and able to withstand repeated use;
b) used primarily and customarily for a medical purpose;

MEDICAID. The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MEMBER. An eligible person who is covered under the Contract (includes Covered Employee and covered Dependents, if any).

MENTAL HEALTH CENTER. A Facility that mainly provides treatment for people with mental health problems. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare or
c) accredited or licensed by the State of New Jersey to provide mental health services.

NETWORK PROVIDER. A Provider which has an agreement directly or indirectly with Us to provide Covered Services or Supplies. The Employee will periodically be given up-to date lists of Network Providers. The up-to date lists will be furnished automatically, without charge.

NEWLY ACQUIRED DEPENDENT. An eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.

NON-BIOLOGICALLY-BASED MENTAL ILLNESS. An Illness which manifests symptoms which are primarily mental or nervous for which the primary treatment is psychotherapy or psychotropic medication where the Illness is not biologically-based.

In determining whether or not a particular condition is a Non-Biologically-based Mental Illness, We may refer to the current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-Covered Services and Supplies, or which exceed any of the limitations shown in the Contract.

NON-NETWORK PROVIDER. A Provider which is not a Network Provider.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:
a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
b) provides medical services which are within the scope of the nurse's license or certificate.

relevant state and local laws, and it must either:
a) be accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b) be approved for its stated purpose by Medicare.
In some places a Rehabilitation Center is called a "rehabilitation hospital."

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

SERVICE AREA. A geographic area We define by county.

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a registered nurse or licensed practical nurse, and require the technical skills and professional training of a registered nurse or licensed practical nurse.

SKILLED NURSING FACILITY. A Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:
a) be accredited for its stated purpose by the Joint Commission; or
b) be approved for its stated purpose by Medicare.

SMALL EMPLOYER. In connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two eligible Employees on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year.

SPECIALIST DOCTOR. A doctor who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine or pediatrics or obstetrics/gynecology (for routine pre and post-natal care, birth and treatment of the diseases and hygiene of females).

SUBSTANCE ABUSE. Abuse of or addiction to drugs. Substance Abuse does not

appropriate Network Hospital to render services if hospitalization is necessary. Decisions as to what is Medically Necessary and Appropriate are subject to review by the Health Net Medical Director. We will not, however, seek reimbursement from an eligible Member for the cost of any covered benefit provided under the Contract that is later Determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a Provider referred in writing by the Primary Care Physician without notifying the Member that such benefit would not be covered under the Contract.

LIMITATION ON SERVICES

Except in cases of Emergency, services are available only from Network Providers. We shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a Member from any Provider or other person, entity, institution or organization unless prior arrangements are made by Us.

PROVIDER PAYMENT

Different providers in Our Network have agreed to be paid in different ways by Us. A Member's Provider may be paid each time he or she treats the Member ("fee for service"), or may be paid a set fee for each month for each Member whether or not the Member actually receives services ("capitation"). If a Member desires additional information about how Our Primary Care Physicians or any other Provider in Our Network are compensated, please call Us at 1-800-956-5565 or write Health Net, P.O. Box 904, Shelton, CT 06484-0944.

The laws of the state of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make Referrals to other health care Providers in which he or she has a significant financial interest inform his or her patients of any significant financial interest he or she may have in a health care Provider or Facility when making a Referral to that health care Provider or Facility. If a Member wants more information about this the Member, the Member should contact his or her physician, chiropractor or podiatrist. If a Member believes he or she is not receiving the information to which the Member is entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 OR (800) 242-5846.

APPEAL PROCEDURE AND COMPLAINT PROCEDURE

INITIAL REQUESTS FOR COVERAGE

In order to appeal, You must have all or part of a request for coverage denied. The time frames for Health Net to respond to a request for coverage are as follows:

a. for requests for Pre-Approval: in a timely manner, but in no event longer than 15 days from date of receipt of the request;

(5) Your coverage type;
(6) the name and address of Our utilization review agent;
(7) the utilization review agent's contact person and telephone number;
(8) a description of the service that was denied, including, as applicable and available, the dates of services, the name of the facility and/or physician proposed to provide the treatment, the developer/ manufacturer of the service;
(9) a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all relevant documents, records and other information;
(10) a statement describing the Stage 3/external appeal procedures offered by Us; specific instructions and forms on how to initiate a Stage 3 external appeal and Your right to obtain further information about such procedures;
(11) a statement of Your right to bring suit under section 502(a) of ERISA;
(12) a copy of any internal rule, guideline or protocol relied upon in making the decision and an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to Your medical circumstances or a statement that such rule, guideline, protocol or similar criterion will be provided upon request and free of charge; and
(13) the following statement: "You and Your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency."

A Stage 3 appeal may be requested if You disagree with the Health Net Stage 2 appeal determination. The Stage 3 appeal is a review of all pertinent information by an external review organization designated by the New Jersey Department of Health and Senior Services.

External appeals are subject to a filing fee of $25 unless financial hardship is demonstrated through evidence of eligibility for the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, General Assistance, SSI; or New Jersey Unemployment Assistance. If there is a determination of financial hardship, the fee shall be reduced to $2. Health Net will facilitate Your filing of an external appeal, including the fowarding to You of the necessary forms, if you contact Us by telephone or in writing. You must fill out and sign an appeal form and a general release of medical records form and mail them, together with the $25 fee (or a $2 fee with evidence of financial hardship) to: Office of Managed Care, Division of Health Care Systems Analysis, P.O. Box 360, Trenton, NJ 08625-0360.

COMPLAINT PROCESS

If You disagree with a Health Net decision that is not a utilization review determination as described above, You or Your representative acting on Your behalf (collectively "You") can use the Health Net grievance process to address Your concern(s).

Your first step is to call the Health Net customer service toll-free number on Your ID card. If after speaking with a representative You are still dissatisfied with the Health Net

decision, You have the right to file a complaint. You have up 180 days from the date of the event to file a complaint. A complaint can be made over the phone by calling the Health Net customer service number on Your ID card, or by writing to: Health Net Customer Service Department, 3501 State Highway 66, Neptune, NJ 07754.

Health Net will make a determination to uphold or reverse the determination that is the subject of Your complaint within 30 days of receipt of the complaint.

The notice of the decision will include:

(1) the date;
(2) the specific reason(s) for the decision;
(3) a clear statement that the notice constitutes the final decision;
(4) Our contact person and telephone number;
(5) Your coverage type;
(6) the name and address and telephone number of Our contact;
(7) a description of any service that was denied, including, as applicable and available, the dates of services, the name of the facility and/or physician proposed to provide the treatment, the developer/ manufacturer of the service;
(8) a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all relevant documents, records and other information;
(9) a statement of Your right to bring suit under section 502(a) of ERISA;
(10) a copy of any internal rule, guideline, protocol or similar criterion relied upon in making the adverse determination, or a statement that such rule, guideline, protocol or similar criterion will be provided upon request and free of charge; and the following statement: "You and Your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency."